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No. 97-218

In The

Supreme Court of the United States

October Term, 1996

STEVEN B. LARSEN, in his capacity as Insurance Commissioner of the State of Maryland,

Petitioner,

vs.

AMERICAN MEDICAL SECURITY, INC., *et al.*,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

RESPONDENTS' BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether the Court of Appeals for the Fourth Circuit was correct in determining that the Employee Retirement Income Security Act of 1974 ("ERISA") preempts a Maryland insurance regulation that forces self-funded ERISA plans that purchase certain levels of stop-loss reinsurance to provide state-mandated health benefits to plan participants.

2. Whether the purchase of stop-loss insurance by an ERISA plan converts a self-funded plan not subject to state regulation into a fully insured plan subject to indirect state regulation.

3. Whether a state law that purports to regulate insurance, but is intended to prevent small employers from forming or maintaining self-funding ERISA plans by eliminating their ability to purchase stop-loss insurance, is preempted by ERISA because: (a) the law is not directed at the business of insurance and, thus, is not saved from preemption; (b) the law is directed at ERISA plans and, thus, cannot be enforced by virtue of the deemer clause; or (c) the law forces ERISA plans to adopt a state-mandated scheme of substantive benefits or risk insolvency.

PARTIES TO THE PROCEEDING

The petition accurately lists the parties to the proceeding.

The parent company of respondent American Medical Security, Incorporated is American Medical Security Group, Incorporated. American Medical Security, Incorporated has no nonwholly owned subsidiaries.

The parent company of respondent United Wisconsin Life Insurance Company is United Wisconsin Services, Incorporated, a publicly held corporation. United Wisconsin Life Insurance Company has no nonwholly owned subsidiaries.

Respondents Client First Brokerage Services, Incorporated; Maran, Incorporated; and Trio Metal Products Company, Incorporated have neither parent companies nor nonwholly owned subsidiaries.

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The ERISA preemption issues presented by this case are of public importance and warrant the consideration of this Court. Consequently, Respondents[1] do not oppose the issuance of this Court's Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit. To the contrary, Respondents respectfully request that this Court issue its Writ in order to affirm the judgment of the Fourth Circuit, and thereby clarify and stabilize a critical area of ERISA preemption analysis.[2]

STATEMENT OF THE CASE

Respondents initiated this action to prevent the Maryland Insurance Administration ("MIA") from impeding the formation and operation of small self-funded ERISA plans by virtually eliminating the ability of those plans to insure themselves against catastrophic losses. Section 9.31.02 of the Code of Maryland Regulations (the "Maryland Regulation") deems stop-loss insurance that attaches below a set point to be "group health insurance." This forces self-funded ERISA plans that require stop-loss protection below those levels to: (a) risk insolvency by forgoing stop-loss protection; (b) terminate health benefits altogether; or (c) provide the benefits mandated by Maryland law. The Regulation reflects the MIA's belief that stop-loss policies that attach at very low levels are simply a sham device by which employers use the guise of self-funding to avoid the

1. The Respondents are American Medical Security, Incorporated ("AMS"), Client First Brokerage Services, Incorporated ("Client First"), Maran, Incorporated ("Maran"), Trio Metal Products, Incorporated ("Trio Metal"), and United Wisconsin Life Insurance Company ("UWLIC").

2. The Petition misrepresents the holding of the Court of Appeals for the Fourth Circuit and the factual and legal context in which the Fourth Circuit reached the conclusions articulated in its Opinion. Respondents, therefore, are constrained to file this Brief in order to correct the statement of the case and to articulate the reasons why this Court should issue its Writ.

cost of offering each of the nearly 50 health benefits mandated by Maryland law.

Both the United States District Court for the District of Maryland and the Court of Appeals for the Fourth Circuit properly concluded that the Maryland Regulation is preempted by ERISA because its articulated purpose and undisputed effect is to force self-funded ERISA plans to offer state-mandated benefits. As the Fourth Circuit concluded:

> The state's fear that plans will circumvent state regulation and offer citizens too few health benefits is understandable. But to state that fear reveals that Maryland is really concerned, not with the business of insurance and its coverage of risks, but with the benefits that ERISA plans can choose to provide their participants and beneficiaries. No matter how understandable this concern may be, only Congress may address it, not the State of Maryland through its insurance regulations.

Pet. App. 12a.

Congress enacted ERISA in 1974 to foster the growth and development of a private system of employee benefit plans and to assure the uniform and national regulation of such plans[3].

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3. ERISA applies to any employee benefit welfare plan ("ERISA plan") established or maintained: (1) by any employer engaged in commerce or in any industry affecting commerce; or (2) by any employee organization or organizations representing employees engaged in commerce or in any industry or activity affecting commerce; or (3) by both. 29 U.S.C. § 1003(a).

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ERISA placed the regulation of employee benefits under federal control, establishing a comprehensive regulatory scheme that was intended to preempt most state laws. By its terms, ERISA "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ." 29 U.S.C. § 1144(a). While exceedingly broad, ERISA preemption is not absolute. In order to maintain parity with the McCarran-Ferguson Act[4], which reserved to the states the right to regulate the business of insurance, ERISA does not "exempt or relieve any person from any law of any State which regulates insurance . . . ." 29 U.S.C. § 1144(b)(2)(A). The exemption from preemption created by the "savings clause" is itself limited by the "deemer clause," which states that an ERISA plan cannot "be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance. . . ." 29 U.S.C. § 1144(b)(2)(B)[5].

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An ERISA plan is:

> any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or any employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits . . .

29 U.S.C. § 1002(1).

4. 59 Stat. 33, as amended, 15 U.S.C. § 1011, *et seq.*

5. Determining whether a state insurance law is preempted by ERISA is a three-step process. First, does the law relate to ERISA plans? If so, under the so-called "preemption clause," the law is preempted unless

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Employers who have chosen to provide health care benefits to their employees generally arrange for the payment of those benefits in one of two ways. First, the employer may purchase a group health insurance policy from an insurance company which pays all health care expenses covered by the group health insurance policy. Second, the employer may create a self-funded medical expense reimbursement ERISA plan through which the employer itself pays for those health care costs for which the employer has chosen to pay.

When an ERISA plan sponsor purchases group health insurance, the plan's role in providing benefits is restricted to the payment of the group health insurance premium. It is the insurance company which issues the group health policy that directly assumes and bears all of the responsibility, and all of the liability, for paying the covered health care expenses of the plan's participants, who are the beneficiaries of the group health policy. The plan itself (usually referred to as an "insured" or "fully insured" plan) pays no claims and has no liability to the plan participants to pay health care benefits. If a dispute regarding a claim for benefits arises, plan participants have no right of action against the plan; the participant's claim is against the insurance company which, by issuing the group health policy, agreed to pay covered health care expenses on behalf of the participant.

In contrast, a self-funded ERISA plan has sole and complete responsibility, and liability, for the payment of participant's covered health care expenses. If a dispute regarding the payment

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it saved. Second, does the state law regulate the business of insurance? If so, the law is exempt from preemption under the savings clause, unless the law runs afoul of the deemer clause. Third, does the law apply to the conduct of the ERISA plan? If so, the law is preempted by the deemer clause and cannot be enforced against ERISA plans.

of a claim for covered expenses arises, the participant's claim is against the ERISA plan itself. No insurance company is liable to participants for the payment of the benefits covered by a self-funded ERISA plan.

The payment method chosen by an ERISA plan determines whether the plan may develop its own benefit package or whether the plan must adopt a state-mandated scheme of substantive benefits. The states may not directly or indirectly regulate self-funded ERISA plans and, thus, cannot dictate the benefits offered by such plans. However, by operation of the savings clause, the states may regulate the substantive terms of insurance policies and, thus, indirectly regulate the benefits offered by fully insured plans. As this Court first concluded in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) and reaffirmed in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), "if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts; if the plan is uninsured, the State may not regulate it." *Id.* at 64.

A fully insured plan pays premium for a group health insurance policy; benefits are paid to beneficiaries (or to health care providers on behalf of beneficiaries) by the insurance company that issued the group policy. The amount paid by the insurance company for the benefit of plan beneficiaries under the group insurance contract does not alter the premium that the insurance company agreed to charge for the group health policy. Thus, for a fully insured plan, the cost of providing benefits does not change during the term of the policy year. The opposite is true of self-funded ERISA plans.

The amount which a self-funded plan expects to contribute to the payment of benefits is based on actuarial estimates of the amount that the plan will be required to pay to health care providers on behalf of plan beneficiaries. The actual amount

that a plan is required to pay could exceed the actuarial estimates and, in some cases, the gap between actual losses and expected losses could render the self-funded plan or its sponsor insolvent. To avoid that possibility, most self-funded ERISA plans take the prudent step of purchasing stop-loss insurance.

Stop-loss insurance is a form of indemnity insurance, in the nature of reinsurance, purchased by self-funded ERISA plans (as well as other self-insuring entities) to protect against unexpected losses. The purchase of stop-loss coverage does not relieve the self-funded plan of its direct obligation to pay benefits to plan participants. Plan participants are neither parties to, nor beneficiaries of the stop-loss insurance contract and have no right of action against the stop-loss carrier.[6] A stop-loss policy does not, as Petitioner repeatedly misstates, pay health claims. Rather, a stop-loss reinsurer reimburses the self-funded plan for claims the plan is obligated to pay in excess of a stated amount known as the "attachment point."[7] As one district court judge

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6. It is this distinction between group health insurance and stop-loss "reinsurance" which is at the heart of this case.

7. A specific (or individual) stop-loss attachment point represents the point at which the stop-loss carrier must reimburse the plan for eligible claims made by individual participants during the plan year. To illustrate, if the specific attachment point is $2,500, the plan always remains liable for the payment of *all* eligible claims submitted by each participant. However, once a given participant's eligible claims exceed $2,500 in a plan year, the plan is entitled to reimbursement from the stop-loss carrier for the amount by which that participant's claims exceed $2,500. Of course, if the plan does not pay the claim or if the plan becomes insolvent and cannot pay the claims, there is no reimbursement by the stop-loss insurer whether the attachment point has been reached or not.

Aggregate stop-loss insurance is purchased by employers to limit the amount that the plan must pay out on behalf of the entire beneficiary

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accurately described it, "[s]top-loss insurance is not group health insurance providing insurance to individuals through a sponsor group. Rather, it is insurance obtained to protect self-insurers from risks beyond those upon which the premiums are based." *Cuttle v. FEMTC*, 623 F. Supp. 1154, 1157 (D. Me. 1985).

The exemption from state insurance regulation afforded self-funded ERISA plans has long been perceived as an impediment to health insurance reform by some state regulators. The Brief filed by the National Association of Insurance Commissioners ("NAIC") as *amicus curiae* in the Fourth Circuit describes activities taken by state insurance regulators to control the insurance market in order to curb perceived abuses and to increase access to health care insurance that conforms to mandates authored by the regulators. However, as the NAIC acknowledges, the efforts of individual states to dictate the kind of health insurance available to its citizens is limited, because federal laws, *particularly* ERISA, restrict the scope of state regulatory power.

The perception of ERISA as a road-block to health care cost "reform" has lead the NAIC and others to seek substantive amendments to ERISA. A specific goal of the "reformers" is the Amendment of ERISA to permit state regulation of self-funded ERISA plans that cover less than fifty participants. The NAIC has repeatedly, but unsuccessfully, urged Congress to

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group in a given plan year. When the total amount of claims paid to participants exceeds a given point (known as the aggregate attachment point), the stop-loss carrier is obligated to reimburse the employer for the amount paid for claims in excess of that point, even if there is a specific attachment point that has not been reached with respect to any particular participant. The aggregate attachment point is generally expressed as a percentage of total expected claims.

eliminate self-funding for small and medium employers and to limit the circumstances in which self-funded plans can purchase stop-loss coverage. Having failed in those efforts, the NAIC has altered its "reform" strategies, drafting model legislation designed to circumvent ERISA and permit state regulators to gain regulatory power over the benefits structures and administration of self-funded ERISA plans by characterizing stop-loss insurance purchased by those plans as "health insurance" unless certain criteria are met.

The Maryland Regulation is based on the NAIC's Model Act.[8] The Regulation deems all ERISA plans to be "employer-sponsored group health insurance coverage" and characterizes stop-loss reinsurance as "stop-loss health insurance coverage." Pet. App. 57a. Any policy or contract issued to an employer that insures losses resulting from employee medical claims is considered to be "a policy or contract of health insurance." Pet. App. 57a-58a. Such a policy "may be considered to be a policy or contract of stop-loss health insurance coverage only if," among other things, the specific attachment points was at least $20,000 and the aggregate attachment point was at least 125% of the plan's expected claims. Pet. App. 58a.

The express purpose of the Regulation is "to define when 'stop-loss' coverage will be considered to be health insurance. . . ." 22 Md. Reg. 913 (1995). The impetus to create

8. The first form of the Maryland Regulation was not proposed until two months after this law suit was filed by Respondents. The initial basis of the Complaint was the MIA's refusal to approve UWLIC's stop-loss insurance policy because the policy did not provide for a minimum specific attachment point of $25,000. The MIA's position was premised on an unwritten, unpublished, informal, internal "policy" of the MIA adopted by unknown persons at an undisclosed point in time for reasons that had never been articulated. This protoplasmic criterion is the long standing regulation of attachment points referenced at page 4 of the Petition.

such a definition was the MIA's "concern[ ] with the protection of the residents of this State against acts by persons and insurers which deprive them of mandated health benefits" and with "the evasion of the insurance regulatory laws of the State." *Id.*

The Regulation was adopted, without a hearing, on August 24, 1995, effective September 24, 1995, and was to apply to all policies issued or renewed after January 1, 1996. The adoption of the Regulation sparked an immediate outcry, particularly by small and medium businesses, which were concerned about the effect of the high minimum attachment points on their ability to self-fund benefits. In light of public reaction, Petitioner held a public hearing in November, 1995 to consider amendments to the Regulation, including the reduction of the minimum attachment points. On December 8, 1995, Petitioner issued an Order explaining the purpose of the Regulation and, among other things, reducing the specific attachment point to $10,000 and the aggregate attachment point to 115% of expected losses. Pet. App. 38a, *et seq.*

The Commissioner's Order confirmed that the purpose of the Maryland Regulation is to control and limit the amount of risk that a self-funded plan can cede to its stop-loss insurer in order to prevent small employer plans from avoiding self-mandated benefits by self-funding. Pet. App. 41a. Indeed, Petitioner has readily acknowledged that the expected losses for small plans might fall well below the attachment points mandated by the Regulation, thereby forcing the small self-funded ERISA plan to: (a) risk insolvency by accepting a level of risk greater than that desired by the plan; (b) become fully insured; or (c) abandon its health plan.

The District Court and the Fourth Circuit correctly concluded that the Maryland Regulation is preempted by ERISA because it directly affects the administration, operation and

viability of self-funded plans. The Regulation dictates as a matter of state policy the amount of loss that a self-funded plan (regardless of size) must absorb before "reinsurance" kicks in, without regard to the judgment of the plan administrators or the size of the plan. For many small employers, the minimum attachment points set by the MIA exceed the level at which a prudent plan would insure itself against excess losses. Thus, the Regulation hinders the formation of small self-funded plans and forces existing plans to either risk insolvency, stop providing health benefits, or abandon self-funding and become fully insured.

Resolving whether the coverage purchaed by an ERISA plan is primary group health insurance or stop-loss reinsurance also resolves whether the plan purchasing the policy is fully insured or self-funded. The distinction is critical, because fully insured plans are indirectly regulated through the plan's insurer and its products, while self-funded plans are not. By relabeling stop-loss insurance as group health insurance, the Regulation purports to define as a matter of state policy when ERISA preempts the application of state laws. Having closed the door on state regulation of ERISA plans, Congress did not then hand the states the key with which to unlock it. The Regulation is but a clever means to do indirectly what the State of Maryland cannot do directly; that is, fulfill its individual vision of health care reform by controlling the benefit structures of self-funded ERISA plans. That, of course, is precisely what the ERISA preemption statute was intended to prevent.

REASONS FOR GRANTING THE WRIT

Respondents agree with Petitioners that this case presents important questions of federal law that have not been, but should be, resolved by this Court. In addition to Maryland, at least 16 other states regulate attachment points in some manner. The

minimum attachment points set by those states vary from the Maryland Regulation and from one another. *See* Petition at 9, n.3. Absent this Court's review and affirmation of the Fourth Circuit's judgment in this case, the patchwork of state regulation that ERISA was intended to eliminate will become a renewed reality for self-funded ERISA plans, particularly those, like Client First, that cover residents of more than one state.

Respondents also acknowledge the body of commentary that perceives disagreement among the Circuits as to whether the purchase of stop-loss insurance by a self-funded ERISA plan subjects the benefit structure of the plan to indirect state regulation. The majority of state and federal courts that have considered this question, including the Courts of Appeal for the Fourth, Fifth and Ninth Circuits, have concluded that stop-loss coverage does not convert an otherwise self-funded ERISA plan into a fully insured one. The Sixth Circuit, however, has reached the opposite conclusion.

While Respondents join in the request for review by this Court, the reasons asserted by Petitioners in support of the Petition are premised on an inaccurate characterization of the Fourth Circuit's opinion and, thus, skew Petitioner's analysis of the importance of this case, the nature of the disagreement among the Circuits and the proper analysis of the issues presented herein in light of prior decisions of this Court. Respondents, therefore, are constrained to address herein the reasons why this Court should issue its Writ in this case.

I.

THIS CASE PRESENTS AN IMPORTANT QUESTION OF FEDERAL LAW WHICH HAS NOT BEEN, BUT SHOULD BE, ADDRESSED BY THIS COURT.

The Fourth Circuit correctly concluded that the Maryland Regulation is a thinly disguised attempt to regulate the benefit structures of ERISA plans is thus preempted. In reaching that conclusion, the Fourth Circuit did not, as Petitioners suggest, prevent states from regulating stop-loss insurance policies. The Opinion acknowledges that "[s]uch regulation is clearly reserved to the states." Pet. App. 15a. The Fourth Circuit held, however, that not every act of a state insurance regulator is properly characterized as the regulation of insurance, and where, as here, the purpose of the state's action is to control the nature of the benefits offered by ERISA plans, the state law is not saved from preemption.

The Fourth Circuit's holding and the reasoning employed by the Court in reaching that holding does not, as Petitioner suggests, conflict with the prior rulings of this Court. The Fourth Circuit has resolved questions of ERISA preemption not directly addressed by this Court in a manner entirely consistent with precedent. The review and affirmation of the Fourth Circuit's opinion will clarify and stabilize a critical area of ERISA preemption analysis.

As this Court has remarked, the preemption framework created by ERISA is not a model of clarity and has spawned much litigation as to the boundaries of state jurisdiction. The first case in which this Court addressed this issue with respect to ERISA plans was *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), which challenged the application of Massachusetts' mandatory benefit laws to group health policies

purchased by ERISA plans. The effect of the Massachusetts law was to require ERISA plans that purchased group health policies to provide benefits that the plans did not want to provide. Thus, the Massachusetts law indirectly regulated the benefit choices of ERISA plans that funded benefits by purchasing group health insurance.

Metropolitan Life held that this indirect regulation of ERISA plan benefits was the inevitable consequence of the right to regulate the business of insurance which is reserved to the states under the savings clause. The Court recognized that its decision "results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not." *Id.* at 747. "By so doing, we merely give life to a distinction created by Congress in the 'deemer clause,' a distinction Congress is aware of and one it has chosen not to alter." *Id.*

Neither *Metropolitan Life* nor the decisions that follow it identify the characteristics of group health insurance that underlie this Court's conclusion that the purchase of that particular insurance product subjects an ERISA plan to indirect regulation of the benefits it provides to beneficiaries. Nor has this Court decided whether the purchase of other insurance products, such as stop-loss insurance, opens the door to the state's indirect regulation of the benefits provided by an ERISA plan. Consequently, debate among the lower courts persists as to the factors that distinguish an insured plan that is subject to indirect regulation from uninsured plan that is not subject to such regulation.[9]

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9. Petitioner contends that the judgment of the Fourth Circuit in this case runs afoul of *Metropolitan Life* and its progeny because the Maryland Regulation focuses on the insurance companies that issue stop-loss insurance and not on the ERISA plans themselves. Pet. 12. According

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The decision reached in *Metropolitan Life* was based on the Court's conclusion that the Massachusetts law was a law that regulated the business of insurance. This Court has not addressed whether a regulation (like the Maryland Regulation) that is created solely for the purpose of influencing the benefit structure of ERISA plans is properly characterized as the business of insurance and, if so, whether such a regulation can survive preemption where (as here) its inevitable and intended consequence is to destroy the self-funded nature of the plan.

In *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), the Court clarified that a state law is not the regulation of the

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to Petitioner, an ERISA plan that purchases stop-loss insurance is an insured plan and, thus, has subjected itself to indirect regulation of its benefit structure. *Id.* at 14. Petitioner argues that:

> ERISA does not pre-empt a State law that regulates insurance contracts merely because, as the court of appeals found to be the situation here, the State law has an indirect effect on employee benefit plans when it uses "insurance policies as a vehicle to impose the requirement of .... health insurance law" on those plans.

Pet. 13, quoting Pet. App. 12a. Petitioner's argument is ill-founded. *Metropolitan Life* provides no support for the proposition that the purchase of any type of insurance product by an ERISA plan subjects that plan to the "use" of the purchased policy as a means of regulating the plan's benefit structure. Petitioner's argument illustrates, however, that the intent of regulations based on the NAIC Model Act is to use the regulation of insurance products as a tool for controlling the benefit structures of ERISA plans. Petitioner would, one must assume, accept the proposition that the State could prohibit all insurance carriers from selling any form of insurance (including fire insurance, workers' compensation insurance, business risk insurance) to employers or employer sponsored plans that fail to provide mandated benefits.

business of insurance merely because the law has some effect upon the insurance industry; the law must be specifically directed toward the industry and may not regulate the conduct of non-insurers. *Id.* at 50. *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), reiterated the breadth of ERISA preemption, emphasizing that, while state regulations must be reviewed in accordance with the traditional three-part preemption analysis, the overarching inquiry is whether the state law violates the goals Congress intended to achieve in enacting ERISA. *Id.* at 57-58. Most recently, in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995), this Court held that state laws of general application that are not specifically directed at or connected to ERISA plans and which have only an indirect economic impact on ERISA plans do not "relate to" the plans and do not trigger preemption. However, the *Travelers* Court recognized that such a law would be preempted if the indirect costs to the ERISA plan were so high that those costs forced the plan to adopt a certain scheme of substantive benefits or effectively restricted the plan's choice of funding, or forced the plan out of existence. *Id.* at 668.

While each of these cases lends guidance to the issue presented by this case, none addresses those issues squarely. This case, however, does present the questions left open by *Metropolitan Life* and its progeny. First, the opinion of the Fourth Circuit is premised, in part, upon the Court's conclusion that the purchase of stop-loss insurance by ERISA plans does not convert otherwise self-funded plans into fully insured plans subject to indirect state regulation. Second, the Fourth Circuit concluded that the Regulation, however artfully drafted, does not regulate the business of insurance because it is directed at the relationship between the plan and its participants and not at the relationship between the plan and its stop-loss insurer. Finally, the Regulation was found to be preempted because its inevitable effect would be to eliminate small self-funded ERISA plans.

In *Travelers*, Mr. Justice Souter seemed to invite the opportunity to review a case like the one at bar when he included the following language as *obiter dicta* in the *Travelers* opinion:

> We acknowledge that a state law might produce such acute, albeit indirect economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers, and that such a state law might indeed be preempted under § 514.

Travelers, 514 U.S. at 668.

This case presents precisely those circumstances described by Mr. Justice Souter and is the ideal vehicle by which this Court may clarify the boundaries of state jurisdiction when state action threatens the autonomy and, indeed, the very existence of certain self-funded ERISA plans.

The Maryland Regulation represents a growing effort by the NAIC and the regulators of at least sixteen other states to overrun the barriers of ERISA preemption and, under the guise of state insurance regulation, heap each state's particular (but frequently divergent) concept of health insurance "reform" upon the large number of self-funded ERISA plans that purchase stop-loss insurance.[10] Because the Fourth Circuit does not encompass all states which regulate stop-loss attachment points, this Court should review and affirm the judgement issued by the Fourth Circuit in this case, thereby ending ongoing state efforts to encroach on ERISA plan practices.

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10. As the Petition states, as of July, 1995, 114 million Americans (44% of the U.S. population) received health insurance benefits through ERISA plans. Forty percent of ERISA plans (covering 44 million people) were self-funded. Over 70% of self-funded ERISA plans purchased some level of stop-loss insurance. Pet. 8-9.

II.

THERE IS A BODY OF COMMENTARY THAT PERCEIVES AN IRRECONCILABLE SPLIT AMONG THE CIRCUIT COURTS.

Consideration by this Court is necessary because, as Petitioner correctly asserts, there are those who perceive a split among the Circuit Courts regarding how, if at all, the purchase of stop-loss coverage effects the self-funded nature of ERISA plans. The Courts of Appeal for the Fourth, Fifth, Sixth, and Ninth Circuit have addressed this issue. The majority view, subscribed to by the Fourth, Fifth and Ninth Circuits, is that stop-loss insurance does not convert an otherwise self-funded plan into a health insurance policy subject to indirect state regulation[11]. Even in the Circuits that have not addressed the issue, the prevailing view of the United States District Courts, including District Courts located in Alabama, Maine, Massachusetts, Minnesota, Pennsylvania, and Wisconsin,[12] is

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11. *See, e.g., Thompson v. Talquin Bldg. Products Co.*, 928 F.2d 649 (4th Cir. 1991) (stop-loss insurance does not convert a self-funded ERISA plan into an insured plan); *Brown v. Granatelli*, 897 F.2d 1351 (5th Cir. 1990), *cert. denied*, 498 U.S. 848 (1990) (state law does not regulate employer's self-insured plan with stop-loss coverage; distinguishes between stop-loss insurance and primary coverage on basis that stop-loss only covers plan itself and plan is still liable to employees; does not reach ERISA preemption issue); *United Food & Commercial Workers & Employers Arizona Health & Welfare Trust v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986) (self-insured ERISA Plan which carries stop-loss insurance is not to be considered a health insurance policy).

12. *Bergin v. Wausau Ins. Co.*, 863 F. Supp. 34, 37, n.4 (D.Mass. 1994) (concluding that ERISA's deemer clause preempted application of state law against plan with stop-loss insurance); *Drexelbrook Engineering Co. v. Travelers Ins. Co.*, 710 F. Supp. 590, 597 (E.D. Pa. 1989), *aff'd*, 891 F.2d 280 (3d Cir. 1989) (recognizing that ERISA plan that purchases stop-loss insurance is the insured, not the individual employees; therefore

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that the purchase of stop-loss insurance does not convert a self-funded plan into a fully insured plan and that stop-loss coverage is not group health insurance.[13] Several state courts have also adopted the majority view.[14]

The majority view, reiterated by the Fourth Circuit in this case, is premised on "the real distinction between self-funded plans, with or without stop-loss insurance, and fully insured plans." App. 12a.

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plan with stop-loss coverage remains uninsured); *Cuttle v. FEMTC*, 623 F. Supp. 1154, 1157 (D. Me. 1985) (holding that stop-loss insurance is not insurance for plan participants, so self-funded plans purchasing stop-loss insurance are not subject to Maine conversion laws); *General Split Corp. v. Mitchell*, 523 F. Supp. 427, 430-431 (E.D. Wis. 1981) (state-mandated benefit statute preempted as applied to self-funded ERISA plan that purchased stop-loss insurance); *St. Paul Elec. Workers Welfare Fund v. Markman*, 490 F. Supp. 931 (D. Minn. 1980) (mandated benefit law preempted as applied to self-funded ERISA plan with stop-loss insurance).

13. *Consumer Benefit Assn. v. Lexington Ins. Co.*, 731 F. Supp. 1510, 1511, 1513 (M.D. Ala. 1990) (noting that any breaches between stop-loss insurer and plan participants in no way affect the plan participant's entitlement to benefits).

14. *Inter Valley Health Plan v. Blue Cross/Blue Shield of Connecticut*, 16 Cal. App. 4th 60, 64, 19 Cal. Repr. 2d 782 (1993) (state insurance regulation of self-funded plans with stop-loss insurance is preempted; despite contrary authority from the Sixth Circuit, the California court found *Pacyga* to be the better reasoned case); *Associated Industs. of Missouri v. Angoff*, 937 S.W. 2d 277, 282-284 (Mo. Ct. App. 1996) (finding that Missouri Insurance Commissioner's authority to regulate health insurance does not extend to stop-loss insurance); *Behavioral Sciences Inst. v. Great-West Life*, 84 Wash. App. 863, 930 P.2d 933 (1997) (concluding that since stop-loss insurer has no obligation to plan participants, employer-sponsor's claims against stop-loss insurer are not preempted by ERISA); *Ramsey Co. Med. Ctr. Co. v. Breault*, 525 N.W. 2d 321 (Wis. 1994) (purchase of stop-loss insurance does not destroy employee benefit plan's status as self-funded).

> Under a self-funded plan, the employer who promises the benefit incurs the liability defined by the plan's terms. That liability remains the employer's even if it has purchased stop-loss insurance and even if the stop-loss insurer becomes insolvent. Conversely, if the employer becomes insolvent, the solvency of the stop-loss insurer may not benefit plan participants and beneficiaries. This is because their claims against the insurer, would be derivative of the plan's claim against the insurer, which arises only after the plan actually makes benefit payments beyond the agreed attachment point. In contrast, when a plan buys health insurance for participants and beneficiaries, the plan participants and beneficiaries have a legal claim directly against the insurance company, thereby securing the benefits even in the event of the plan's insolvency. Participant and beneficiaries in self-funded plans may not have the security of the insurance company's assets because stop-loss insurance insures the plan and not the participants.

Pet. App. 13a.

The Court of Appeals for the Sixth Circuit is the only Circuit Court which has ever concluded that the purchase of a form of stop-loss coverage can convert a self-funded ERISA plan into a fully insured plan subject to indirect regulation by the State.[15]

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15. *See, e.g., Lincoln Mutual Casualty Co. v. Lectron*, 970 F.2d 206 (6th Cir. 1992); *Northern Group Servs., Inc. v. Automobile Owners Ins.*

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The Sixth Circuit reasons that under *Metropolitan Life*, which applied specifically to fully insured plans, state insurance laws are not preempted under ERISA, and that "the 'stop-loss' nature of the plans does not alter [that] conclusion." *Michigan United Food and Commercial Worker Unions v. Baerwaldt*, 767 F.2d 308, 312 (6th Cir. 1985), *cert. denied*, 474 U.S. 1059 (1986)[16].

The minority view of the Sixth Circuit is wrong because it misconstrues the nature of stop-loss insurance. The Sixth Circuit fails to recognize any distinction between standard health plans and stop-loss insurance in reasoning that "[a]s long as the [ERISA] plans purchase insurance from 'an insurer offering health insurance policies in' Michigan, the policies must include the substance abuse coverage specified [under Michigan law]." *Baerwaldt*, 767 F.2d at 313. Also, the Sixth Circuit's holdings completely fail to consider the effect of the state laws on Congress' goal of achieving uniformity for ERISA plans.

The Fourth Circuit noted the Sixth Circuit's *Northern Group* holding, but found the reasoning to be unpersuasive:

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Co., 833 F.2d 85 (6th Cir. 1987), *cert. denied*, 486 U.S. 1017 (1988), *overruled in part* by *Lincoln Mutual, supra*; *Michigan United Food and Commercial Worker Unions v. Baerwaldt*, 767 F.2d 308 (6th Cir. 1985), *cert. denied*, 474 U.S. 1059 (1986).

16. At least one federal court within the Sixth Circuit has concluded that the reasoning of *Baerwaldt* is unsound and that, in light of this Court's holding in *FMC Corp. v. Holliday*, *Baerwaldt* and its progeny are no longer good law. *See Auto Club Ins. Ass'n v. Saveco Life Ins. Co.*, 833 F. Supp. 637, 642 (W.D. Mich. 1993) (holding that stop-loss insurance is not a policy for health benefits and stating that: "[t]he rational for not treating stop-loss insurance as health insurance is better explained by rulings in other circuits," such as the Fourth Circuit, rather than by Sixth Circuit precedent).

> Even with the stop-loss coverage, Talquin's Plan is directly liable to Talquin's employees for any amount of benefits owed to them under the Plan's provisions. The purpose of the stop-loss insurance is to protect Talquin from catastrophic losses, it is not accident and health insurance for employees. Instead of covering employees directly, the stop-loss insurance covers the Plan itself. Thus, for the purposes of ERISA, the Plan remains self-funded even with the stop-loss insurance.

Talquin, 928 F.2d 649, 653.

The existence of the NAIC Model Act, the Maryland Regulation and stop-loss regulations promulgated by other states establishes that, as long as it can be reasonably argued that the Sixth Circuit stands against the majority, states will continue to use the existence of stop-loss coverage as an excuse to manipulate and control ERISA plan benefits. The time is ripe to resolve the conflict created by the Sixth Circuit's renegade rulings and to make clear to state regulators that the purchase of stop-loss insurance by a self-funded ERISA plan does not subject those plans to any form of state regulation.

CONCLUSION

This Court should issue its Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit, not for the reasons articulated by Petitioner, but for those asserted herein by Respondents. Following review, the judgment of the Fourth Circuit should be affirmed.

Respectfully submitted,

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